MIAMI-DADE COUNTY

2009 MIAMI-DADE BENEFITS ELECTION FORM FOR GROUP HEALTH PLANS

(*Please refer to INSTRUCTIONS on reverse side)

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. F.S. Section 817.234 (1) (b) (2002) FL

SOCIAL SECURITY NUMBER

LAST NAME | FIRST NAME | MI

ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE ( ) - | WORK PHONE ( ) - | DATE OF BIRTH | DATE OF HIRE

SEX: ☐ Male ☐ Female

STATUS: MARK ONE: ☐ Open enrollment ☐ New hire ☐ Change in status ☐ Transfer

EFFECTIVE DATE | EMPLOYEE STATUS | DEPARTMENT | BARGAINING UNIT

GROUP HEALTH PLANS (RATES INDICATED ARE BIWEEKLY)

6. MEDICAL Your current enrollment is for:
You must complete to select your medical plan for 2009.
☐ No Medical Coverage Requested.

	AVMED POS	AVMED HMO HIGH	AVMED HMO LOW
Employee only	☐ 12.35	☐ .00	☐ .00
Employee + Child(ren)	☐ 220.03	☐ 138.67	☐ 130.78
Employee + Spouse / Domestic Partner (DP)	☐ 265.19	☐ 160.06	☐ 150.97
Employee + Family	☐ 458.42	☐ 219.22	☐ 206.85

Union Plan ☐ FIRE*
*UNION CONFIRMATION REQUIRED

	JMH HMO HIGH	JMH HMO LOW
Employee only	☐ .00	☐ .00
Employee + Child(ren)	☐ 138.67	☐ 130.78
Employee + Spouse / Domestic Partner (DP)	☐ 160.06	☐ 150.97
Employee + Family	☐ 219.22	☐ 206.85

7. DENTAL Your current enrollment is for:
Complete only if you wish to make a change to your dental plan for 2009.
☐ No Dental Coverage Requested.

	STANDARD METLIFE	STANDARD ADP	STANDARD OHS	ENRICHED METLIFE	ENRICHED ADP	ENRICHED OHS
Employee only	☐ .00	☐ .00	☐ .00	☐ 4.68	☐ 1.25	☐ 1.25
Employee + one dependent	☐ 14.82	☐ 2.60	☐ 2.60	☐ 24.07	☐ 4.69	☐ 4.69
Employee + dependents	☐ 33.16	☐ 6.09	☐ 6.09	☐ 48.09	☐ 9.80	☐ 9.80

8. OPTIX VISION PLAN Your current enrollment is for:
Complete only if you wish to make a change to your vision plan for 2009.
☐ No Vision Coverage Requested.

☐ Employee only 2.06 ☐ Employee + one dependent 4.12 ☐ Employee + dependents 7.57

9. DEPENDENT INFORMATION If you made any changes for 2009, complete for all dependents to be covered.
New participants must select a primary care physician if enrolling for a low option HMO plan.
New participants in a prepaid dental plan must select a dental provider.

Last	First	Social Security #	D.O.B MM/DD/YYYY	Sex	PCP Name	PCP #	Dental Provider #	Medical	Vision	Dental
Employee				☐M ☐F				☐	☐	☐
Spouse/ Domestic Partner				☐M ☐F				☐	☐	☐
Child				☐M ☐F				☐	☐	☐
Child				☐M ☐F				☐	☐	☐
Child				☐M ☐F				☐	☐	☐
Child				☐M ☐F				☐	☐	☐
Child				☐M ☐F				☐	☐	☐
Child				☐M ☐F				☐	☐	☐

If you have any additional children to cover, mark here. ☐ Contact your DPR for information.
Are any of the dependents listed above new for 2009? ☐ YES ☐ NO
Are you or any members of your family covered by any other health insurance? ☐ YES ☐ NO

MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND AGREED TO THE TERMS AND CONDITIONS ON THE REVERSE SIDE OF THIS APPLICATION.

10. SIGNATURE | DATE

S0000002

GROUP MEDICAL, DENTAL PLANS AND OPTIX VISION PLAN

6. Review your current medical coverage. Complete this section to select your medical coverage for 2009. Please mark the appropriate box indicating which coverage you are electing, even if you are staying in the same medical plan, if you wish to add or delete dependents from your plan, this is a change.

7. Review your current dental coverage. Complete this section only if you wish to make a change for 2009. If you wish to make a change, please mark the appropriate box indicating which coverage you are electing. Even if you are staying in the same dental plan, if you wish to add or delete dependents from your plan, this is a change.

8. Review your current OPTIX vision coverage. If you wish to make a change (ex., add or delete dependents, enroll for coverage or cancel coverage), please complete this section. This plan is available to all eligible employees regardless of Union affiliation.

9. If you made any changes to your medical, dental or vision plan for 2009:
   - List yourself and all dependents you wish to cover in 2009 for medical, dental or vision.
   - Provide social security number for each dependent.
   - Provide sex and date of birth.
   - All low option HMO plan enrollees must select a primary care physician.
   - New enrollees in a prepaid dental plan must select a dental provider.
   - Fill in bubbles under medical/dental/vision columns to indicate those enrollees who will be covered for medical, dental and/or vision coverage.
   - Contact your departmental personnel representative if any additional space is required for listing dependents.
   - Indicate if any of the dependents listed are new.
   - Indicate whether you or other covered family members have other health insurance.

10. Carefully read the section below marked "Important Terms and Conditions," then sign and date your forms. Make a copy of this form for your records.

IMPORTANT TERMS AND CONDITIONS

- I authorize my employer to deduct from my pay the applicable premium contribution to maintain the benefit coverage's I selected, including any return check service fees in accordance to Florida Statute 832.07, if my personal check or money order submitted while on leave without pay status, is returned by the bank for insufficient funds.

- I certify that the information supplied in this application is true to the best of my knowledge.

- I understand that once this form is submitted, I cannot request a change of medical insurance carrier, dental plan carrier or vision plan carrier until the enrollment for 2010. A change of coverage type may be requested to add a newly acquired dependent within 45 days of the event (60 days for newborns), or to add or delete existing dependents subject to the requirements of Flexible Benefits and HIPAA. Please refer to the 2009 Benefits Handbook for specifics.

- I agree to complete and submit to any provider of health services such consents, release, and other assignments as are reasonably necessary for any provider in accordance with its rights under the health benefit plans or insurance policies. This authorization includes psychiatric and substance abuse records as well as concurrent inpatient review.

- I authorize any provider of health services to release, upon written request, any information concerning the health, condition, or treatment of any covered person whenever such information is considered necessary for the proper disposition of a claim submitted for payment or in fulfillment of obligations

- I understand that eligible unmarried, dependent children may be covered until the end of the calendar year in which the child reaches age 19. Coverage may be extended to the end of the calendar year in which the child reaches age 25 provided that the child is primarily dependent upon the insured for support and living in the household of the insured, or the child is a full-time or part-time student. Unmarried dependent children from age 25 to age 30 (end of calendar year) may be covered if: 1.) the child is unmarried and does not have any dependents of their own, 2.) the child is a resident of the state of Florida, or a part-time or full time student. Premium for this group will be deducted post tax and subject to imputed income tax. See Benefits Handbook for more specifics. Documentation will be required. Failure to provide the documentation will make the dependent ineligible. Contact the plan regarding extension of benefits for disabled dependents.

- I understand if a new dependent has a different last name than mine, legal documentation evidencing dependent status must be attached to this completed form and submitted to Benefits Administration Unit or your DPR.

- Premiums attributable to a domestic partner or their children will be deducted post tax and subject to imputed income tax.

NEW HIRES

- I understand I must submit legal documents (example: marriage certificate, birth certificate, certificate of domestic partnership, etc.) to the Benefits Administration Unit of Risk Management, GSA evidencing the relationship of all dependents listed with the same last name as mine, when I submit my enrollment form. My dependent(s) will not be enrolled without the legal documentation.

- I agree for myself and covered members of my family to be bound by the benefits, deductibles, co-payments, exclusions, limitations, and other terms of the Contract, Agreement and Plan Documents.

2009 MIAMI-DADE BENEFITS ELECTION FORM FOR GROUP LEGAL SERVICES, DISABILITY INCOME PROTECTION AND FLEXIBLE BENEFITS

(*Please refer to INSTRUCTIONS on reverse side)

SOCIAL SECURITY NUMBER

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LAST NAME | FIRST NAME | MI

ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE ( ) - | WORK PHONE ( ) - | DATE OF BIRTH | DATE OF HIRE

STATUS: MARK ONE
☐ Open enrollment ☐ New hire
☐ Change in status ☐ Transfer

EFFECTIVE DATE | EMPLOYEE STATUS | DEPARTMENT | BARGAINING UNIT

ALL RATES ARE BI-WEEKLY EXCEPT IN SECTION 3

IF YOU WISH TO PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT (S), AND/OR MAKE ANY CHANGES TO YOUR BENEFITS, YOU MUST COMPLETE THE APPROPRIATE SECTIONS AND SIGN THE FORM.

GROUP LEGAL SERVICES (After-Tax)

1. Your current enrollment is:
   Complete only if you wish to make a change to your Group Legal Plan for 2009.

   ☐ Cancel Coverage

   ☐ Employee only $7.37
   ☐ Employee and one dependent $9.45
   ☐ Employee and Dependents $9.72

2. DISABILITY INCOME PROTECTION (After Tax) You may select one option from either or both plans.
   Your current enrollment is:
   Complete to enroll for or cancel benefits for 2009.

☐ Cancel short-term disability (STD)

MetLife STD (After-Tax)

	Premium per $100 Weekly Benefit
☐ Low Option ($500 max weekly benefit)	$1.54
☐ High Option ($1,000 max weekly benefit)	$1.54

☐ Cancel long-term disability (LTD)

MetLife LTD (After-Tax)

	Premium per $100 of Covered Monthly Payrol
☐ Low Option ($2,000 max mo. benefit)	$0.26
☐ High Option ($4,000 max mo. benefit)	$0.31

THE SHORT-TERM AND LONG-TERM DISABILITY COVERAGE THAT REQUIRE MEDICAL EVIDENCE (EOI) WILL NOT BECOME EFFECTIVE UNTIL YOUR APPLICATION IS APPROVED BY MetLife.

3. SPENDING ACCOUNTS If you wish to participate in either or both Flexible Spending Accounts for 2009, you must complete this section by entering the ANNUAL DOLLAR AMOUNT.

A. HEALTHCARE SPENDING ACCOUNT

B. DEPENDENT CARE SPENDING ACCOUNT

IMPORTANT

These benefits apply to plan year 2009 only. The County necessarily reserves the right to amend or terminate any of the benefits at any time.

I certify that the information supplied in this application is true to the best of my knowledge.

I herby authorize my employer to reduce my gross salary before Federal and Social Security taxes are calculated by the total amount of annual salary reduction indicated above in the election I made in Section 3.

I hereby authorize my employer to deduct from my pay any benefits I have elected on after-tax basis.

I understand that the cost of disability income protection plan(s) for plan year 2009 will be based on salary and option(s) selected.

I understand the contribution to my Social Security account may be reduced if contributions will be based on my income after reduction.

I understand that the funds in the Spending Accounts can be used only to reimburse payment of expenses incurred during the plan year or the grace period, if applicable and while participating in the plan. Any amount remaining in a Spending Account that is not used during this period will be forfeited. Expenses for a Domestic Partner and their children are not reimbursable. Also, expenses for overage children who meet the criteria of FSS 627.6562 are not reimbursable.

I understand that the funds in the Spending Accounts cannot be used to reimburse expenses covered by another plan.

I understand that expenses for which I am reimbursed cannot be claimed on my income tax returns or eligible for coverage under any other insurance plan.

I understand that the amount of salary reduction will include the items specified above and will continue in effect throughout 2009 unless I terminate employment or file an approved Change in Status before the end of the year.

I understand and agree that my employer and benefit plans will not incur any liability resulting for my failure to sign or accurately complete this election form.

I agree for myself and covered members of my family to be bound by the benefits, deductibles, co-payments, exclusions, limitations and other terms of the Contracts, Agreements and Plan Documents.

I understand that my Group Health premiums will automatically be paid tax-free through salary reduction. Any premium attributable to a domestic partner and their child(ren) or children over age 25 will be post tax and subject to imputed income tax.

4. FEES will be charged where applicable. See reverse side for amounts. S0000001

5. SIGNATURE | DATE

INSTRUCTIONS

Fill each bubble completely
Example: ☐ ☒ ■ ☐
Erase completely to change
Make NO Stray marks on the form
Make a copy of this form for your records.
Please read your "2009 Benefits Handbook" carefully to make informed choices

Report any changes to your personal information located at the top of your form to your DPR.

Spending Accounts Example:

How to mark Spending Account Boxes:
Example: $500.00 annual contribution

0	5	0	0	0	0

IMPORTANT NOTICE TO NEW HIRES:

You must also complete a beneficiary designation for life insurance. Please contact your DPR for further information.

GROUP LEGAL SERVICES PLAN

1. Review your current coverage. Make your elections for 2009.
   Cover only those dependents who may utilize this plan.

2. Disability Income Protection
   Review your current coverage. Add and/or cancel the coverage you want for 2009 by marking the appropriate box(es).
   STD Low Option : Biweekly Premium = Adj. Biweekly Salary (capped at $1,666.67) ÷ 2 x 0.60 x 0.0154
   STD High Option : Biweekly Premium = Adj. Biweekly Salary (capped at $3,333.34) ÷ 2 x 0.60 x 0.0154
   LTD Low Option : Biweekly Premium = Adj. Biweekly Salary (capped at $1,538.76) x 26 ÷ 12 x 0.0026
   LTD High Option : Biweekly Premium = Adj. Biweekly Salary (capped at $3,077.52) x 26 ÷ 12 x 0.0031
   (Visit the online calculator @ http://www.miamidade.gov/benefits/calculator)

FLEXIBLE BENEFITS PLAN

3. Flexible Spending Accounts
   Review your current elections. You must complete this section if you wish to participate in either or both Spending Accounts for 2009.
   A. Healthcare Spending Account
   - Refer to the worksheet in your "2009 Benefits Handbook."
   - Minimum annual contribution: $260 for the full plan year
   - Maximum annual contribution: $5,000 less administrative fee of $1.96, or $4,949.04
   - Write the annual amount in the boxes provided.

   B. Dependent Care Spending Account
   - Refer to the worksheet in your "2009 Benefits Handbook."
   - Minimum annual contribution: $260 for the full plan year
   - Maximum varies depending on your tax filing status:
     - Married, filing separately, Maximum: $2,500 less administrative fee of $1.96, or $2,449.04
     - Married, filing jointly, maximum: $5,000 less administrative fee of $1.96, or $4,949.04
     - Single, head of household, maximum: $5,000 less administrative fee of $1.96, or $4,949.04
   - Write the annual amount in the boxes provided.

4. Fees
   The biweekly administrative fees are as follows:
   - Healthcare Spending Account $ 1.96
   - Dependent Care Spending Account $ 1.96

   Maximum Biweekly fee: $1.96

5. Carefully read the section marked "Important." If you made any changes to your benefits or you are participating in a Flexible Spending Account(s), please sign, date and return your form.